



Beneficiary Designation Instructions

ING Life Insurance and Annuity Company
151 Farmington Avenue
Hartford, CT 06156-8040
Telephone: 1-800-584-6001
Fax: 1-860-723-9637

ING Life Insurance and Annuity Company will be defined as “the Company”, “we”, “us”, or “our” in this document.

| | | |
|---|---|--|
| Good Order | Good Order is receipt at our Hartford Service Center of this form accurately completed, and must include the date and signature of you, the Participant. If this form is not received in Good Order, as determined by us, it may be returned to you for correction and processed upon resubmission in Good Order at our Hartford Service Center. | |
| Instructions for completing the Beneficiary Designation Form | <ol style="list-style-type: none">Participant's signature should be witnessed. The witness need not be a Notary Public. Note: A person designated as a Beneficiary should not act as a witness.Please indicate your full legal name and the full legal name of each designated Beneficiary(ies).<ul style="list-style-type: none">A married woman should be indicated by her own given name, not that of her husband. Example: Mary N. Jones, not Mrs. John R. JonesDo not designate a Beneficiary by relationship or class (<i>e.g., my children</i>). Each Beneficiary must be specifically named.If more than one Beneficiary is designated, payment will be made in the percentages designated (<i>or in equal shares</i>) to the Primary Beneficiaries who survive the Participant, or if none survive the Participant, payment will be made in the percentages designated (<i>or in equal shares</i>) to the Contingent Beneficiaries who survive the Participant.Your Beneficiary data will be administered based on the Right of Survivorship, unless otherwise provided by your Employer's Plan. This means that, in order to receive a death benefit a Beneficiary must be living. For example, if you named three equal Primary Beneficiaries and one were to predecease you, the surviving Beneficiaries would receive the full value of your Plan account (<i>i.e., 50% to each living Beneficiary</i>).If there are no surviving Primary or Contingent Beneficiaries, payment will be made pursuant to terms of the Plan.All designations must be in whole percentages. See the 2nd example below for an odd-numbered Beneficiary Designation. Total percentage must equal 100% for Primary Beneficiary and 100% for Contingent Beneficiary (<i>if designated</i>).If you need further assistance, please contact one of our customer service associates at the number above.Please keep a copy for your records. Mail the original to the address shown on this form. | |
| Common Beneficiary Designations | Type of Beneficiary | Examples of Designation(s) |
| | One Beneficiary | Mary R. Jones, Spouse, 100% Primary |
| | Two or more Beneficiaries, All designations must be in whole percentages | Mary R. Jones, Spouse, 34% Primary Eric A. Jones, Jr., Child, 33% Primary Kevin R. Jones, Child, 33% Primary |
| | Primary and Contingent Beneficiaries | Mary R. Jones, Spouse, 100% Primary Eric A. Jones, Jr., Child, 50% Contingent Kevin R. Jones, Child, 50% Contingent |
| | Participant's Estate | Participant's Estate |
| | Trustee | John Doe, Trustee under trust agreement* dated . . . * IRS Regulations apply when a trust is named as Beneficiary. We will forward further information and instructions to you if this situation is applicable. |



Beneficiary Designation

☐ Initial Designation

☐ Change to Designation

Mail or Fax completed form to:
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Hartford, CT 06156-8040

Fax: 1-860-723-9637

| | | | |
|--|---|--|----------------------------|
| Plan Information | Plan Name District of Columbia Deferred Compensation Plan | Plan No. 666775 | |
| Participant Information | Participant Name (Last, First, Middle Initial) | | |
| | Daytime Telephone No. () | Evening Telephone No. () | |
| Beneficiary Information <i>Please print.</i> <i>Changes must be initialed by the Participant.</i> <i>If additional space is needed, attach a separate page and include all the information shown here.</i> <i>* Total Percentage must equal 100% for Primary Beneficiary and 100% for Contingent Beneficiary (if designated).</i> <i>** Contingent Beneficiary(ies) will only receive payment if all Primary Beneficiaries have predeceased the Participant.</i> | Beneficiary Name and Address (complete legal name required) <input checked="" type="checkbox"/> Primary Beneficiary Percentage* | | |
| | Relationship | Social Security No. | Date of Birth (mm/dd/yyyy) |
| | Beneficiary Name and Address (complete legal name required) <input type="checkbox"/> Primary Beneficiary OR <input type="checkbox"/> Contingent Beneficiary** Percentage* | | |
| | Relationship | Social Security No. | Date of Birth (mm/dd/yyyy) |
| | Beneficiary Name and Address (complete legal name required) <input type="checkbox"/> Primary Beneficiary OR <input type="checkbox"/> Contingent Beneficiary** Percentage* | | |
| | Relationship | Social Security No. | Date of Birth (mm/dd/yyyy) |
| | Beneficiary Name and Address (complete legal name required) <input type="checkbox"/> Primary Beneficiary OR <input type="checkbox"/> Contingent Beneficiary** Percentage* | | |
| | Relationship | Social Security No. | Date of Birth (mm/dd/yyyy) |
| | Signatures | | |
| | Unless otherwise noted: <ul style="list-style-type: none">• Subject to the terms of my Employer's Plan, I request that any sum becoming due upon my death be payable to the Beneficiary(ies) designated above. I understand this designation will supercede all prior Beneficiary designations made by me under my Employer's Plan.• If more than one Beneficiary is designated, payment will be made in the percentages designated (or in equal shares) to the Primary Beneficiaries who survive the Participant or, if none survive the Participant, payment will be made in the percentages designated (or in equal shares) to the Contingent Beneficiaries who survive the Participant.• If a percentage is not designated, it will be assumed that you wish the value of your Plan Account to be split equally among all Designated Beneficiaries.• If no Beneficiary survives the Participant, payment will be made pursuant to the terms of the Plan. | | |
| Signed in (City/Town and State) | | Date of Participant's Signature (required) (mm/dd/yyyy) | |
| Participant Name (please print) | | Witness Name (please print) | |
| Participant's Signature (required) | | Witness's Signature (see instructions) | |